DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 10/11/14

PRINTED: 09/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445160	A. BUILDING _____ B. WING _____	08/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to ensure dignity was maintained for one resident (#113) of twenty-one residents on one hallway of four hallways observed. The findings included: Resident #113 was admitted to the facility on June 5, 2013, with diagnoses including General Muscle Weakness, Cerebrovascular Accident, Dysphagia, Constipation, Vascular Dementia, and Hypertension. Medical record review of the Annual Minimum Data Set (MDS) dated June 9, 2014, revealed the resident scored 8 out of 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. Continued review of the MDS revealed the resident required extensive assistance of one person for bed mobility, transfers, dressing, toilet use, and personal hygiene. Observation on August 26, 2014, at 3:07 p.m., on the 400 hallway, revealed resident #113 lying on the bed near an open door, with a sheet covering the resident's upper torso and head. Continued observation revealed the resident's lower torso	F 241	Preparation and execution for this plan of correction does not constitute an admission or agreement by the provider for the truth of the facts alleged or conclusions set forth or the conclusions set forth in the alleged deficiencies. This plan of correction prepared and/or executed solely because it is required by the provisions of the Federal and State law. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY Resident' # 113 care-plan was adjusted on 9-11-14 to reflect his preference to cover his head with a sheet while lying in bed. A one time audit was conducted on 9-15-14 to identify if any other residents prefer to pull a sheet over their head while lying in bed. CNA # 1 was in-serviced regarding leaving resident # 113 lower torso uncovered exposing his incontinence brief by DON on 9-15-14. Licensed staff will be in-serviced by Staff Development Coordinator on importance of maintaining resident dignity while maintaining his or her preference.	9-27-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelly Boyd — TITLE: Administrator — (X6) DATE: 9/18/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 and legs were not covered, and the resident was wearing an incontinence brief. Continued observation at 3:11 p.m., revealed the Certified Nurse Aide (CNA) #1 walked to the doorway of the resident's room, paused, looked in the room, and walked away. Continued observation at 3:13 p.m., revealed CNA #1 walked past the resident's room for a second time, without entering the room. Review of the facility policy, Dignity, effective August 1, 2012, revealed, "...ensure residents are cared for in a manner and in an environment that maintains or enhances...dignity and respect..." Interview with Registered Nurse #1 on August 26, 2014, at 3:14 p.m., confirmed, "...the resident should be covered...the resident likes to cover...head..." Interview with the Director of Nursing (DON) on August 27, 2014, at 7:56 a.m., in the DON's office, confirmed, "...leaving the resident uncovered was not acceptable...should provide privacy..."	F 241	Risk Manager or Unit Manager will audit this residents preference at the same time preserving his dignity. 3x week x4 weeks 2x weekx4 weeks 1x week x 4 weeks then re-evaluate continued need to audit based on findings. Results of Audits will be reviewed at the Quality Assurance Process Improvement Committee Meeting monthly x 3 months then re-evaluate need to continue monitoring thereafter. Quality Assurance Process Improvement Committee is comprised of : Administrator, Director of Nursing, Medical Director, Social Services Director, Risk/Restorative Nurse, Unit Managers, Dietary Manager, Staff Development Coordinator, Wound Nurse, Health Information Manager.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:	F 272	483.20(b)(1) COMPREHENSIVE ASSESSMENTS A treatment order was obtained for resident # 11 on 8-27-14. A weekly skin assessment for resident # 11 was completed on 8-27-14.	

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F 272	Continued From page 2 Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to assess two residents (#11, #111) of three residents reviewed for non-pressure related skin conditions of thirty-five residents reviewed. The findings included: Resident #11 was admitted to the facility on May	F 272	CNA # 2 was in-serviced regarding lack of documentation related to resident # 11 change in skin condition by DON 9-15-14. LPN # 2 was in-serviced regarding lack of documentation and failure to obtain a treatment order for resident # 11 by DON on 9-15-14. An investigation of resident #111 bruise was completed on 8-26-14. A skin assessment for resident #111 was completed by Unit Manager on 8-26-14. Body Audits were completed on all in-house residents. 8-27-14 Licensed staff will be in-serviced by Staff Development Coordinator on Care System Guidelines-skin. 9-27-14 Facility will continue with paper documentation of weekly skin assessments.	

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F 272	Continued From page 3 15, 2014, with diagnoses including Anxiety, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Senile Delusions, Senile Depressive Disorder, Senile Dementia, and Psychosis. Medical record review of the Annual Minimum Data Set (MDS) assessment dated June 9, 2014, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating the resident was cognitively intact. Medical record review of the Care Plan revised June 11, 2014, revealed a nursing diagnosis for Impaired Skin Integrity/Skin Tears. Continued review revealed interventions for identifying impaired skin integrity included "...skin audit as needed, and report abnormal results to the physician and the treatment nurse..." Medical record review of the Weekly Skin Assessment dated August 20, 2014, revealed no documentation resident #11 had impaired skin integrity. Medical record review of the CNA 24 Hour Communication Reports dated August 22, through August 26, 2014, revealed no documentation resident #11 had changes in skin condition. Observation of the resident on August 25, 2014, at 12:30 p.m., in the resident's room, revealed the resident had an abrasion with a scab on the left earlobe, and an abrasion with a scab on the left elbow. Review of the facility's policy, Skin Care (undated), revealed, "...residents will be	F 272	DON or Unit Manager will audit CNA/LPN skin documentation with actual resident to ensure accuracy, 4 residents : 3x week: x4 weeks 2x week: x4 weeks 1x week x 4 weeks then re-evaluate continued need to audit based on findings. Results of Audits will be reviewed at Quality Assurance Process Improvement Committee meeting monthly for 3 months then re-evaluate need to continue monitoring thereafter. Quality Assurance Process Improvement Committee meeting is comprised of the: Administrator, Director of Nursing, Medical Director, Social Services Director, Risk/ Restorative Nurse, Unit Managers, Dietary Manager, Staff Development Coordinator, Wound Nurse, Health Information Manager.	

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F 272	Continued From page 4 observed by the Certified Nursing Aide (CNA) daily. changes will be reported to the licensed nurse and documented..." Further review revealed, "...when an open area is identified: implement resident specific interventions immediately...document evaluation of wound in electronic medical record..." Interview with resident #11 on August 25, 2014, at 12:30 p.m., in the resident's room, confirmed the resident had scratched a "bump" on the left earlobe, causing the "bump" to bleed. Continued interview confirmed the resident had hit the left elbow on the bathroom door. Continued interview confirmed the resident could not remember when this occurred. Interview with Licensed Practical Nurse (LPN) #2 on August 26, 2014, at 12:40 p.m., on the 300 hall, confirmed the LPN was notified by CNA #2 of bleeding to the resident's left earlobe a few days earlier. Continued interview confirmed the LPN acknowledged treating the resident's earlobe to stop the bleeding at the time of the injury. Continued interview confirmed no additional skin assessment had been completed. Interview with the Wound/Treatment Nurse on August 26, 2014, at 3:40 p.m., in the MDS office, confirmed the Treatment Nurse was unaware of the abrasion to the left earlobe and the left elbow. Interview and medical record review with LPN #4, at the South Nurses Station, on August 27, 2014, at 9:05 a.m., confirmed there was no documentation in the nurse's notes or assessment in the electronic record of the abrasions to the left earlobe and the left elbow for resident #11.	F 272		

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F 272	Continued From page 5	F 272		

Resident #111 was admitted to the facility on August 30, 2013, with diagnoses including Chronic Airway Obstruction, Peripheral Vascular Disease, Diabetes Mellitus, Hypertension, and Failure to Thrive.

Medical record review of the Braden Risk Assessment Report dated May 6, 2014, revealed the resident's risk score was "19" indicating minimal risk.

Medical record review of the MDS dated August 2, 2014, revealed the resident scored 8 out of 15 on the Brief Interview for Mental Status, indicating moderate cognitive impairment. Continued review of the MDS revealed the resident required minimal assist of one person for bed mobility, transfers, toileting, and personal hygiene.

Medical record review of the skin assessment dated August 22, 2014, revealed no alteration in skin integrity had been identified.

Observation on August 26, 2014, at 8:00 a.m., revealed the resident seated in a wheelchair in the resident's room. Continued observation revealed a quarter-size, bruise-like area, on the resident's left forearm, approximately three inches below the bend of the elbow.

Review of the Care System Guideline, Skin Care (undated), revealed, "...Weekly review of the patient's skin will be completed by the nurse and documented in the electronic medical record. Residents will be observed by the CNA (Certified Nurse Aide) daily for reddened/open areas and edema of feet or sacrum. Changes will be

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F 272	Continued From page 6 reported to the licensed nurse and documented..." Interview with the Unit Manager at the South Nurses Station, on August 26, 2014, at 3:51 p.m., confirmed the resident had a shower (August 25, 2014), and no information had been reported regarding the bruise-like area. Continued interview confirmed,"The facility's expectation is for all bruises to be reported to the charge nurse, and an incident report completed." Continued interview confirmed the resident had not been assessed regarding the bruise-like area on the resident's left forearm.	F 272		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations, facility policy review, and interview, the facility failed to provide services and care in accordance with the physician's order for one resident (#27) of thirty-two residents reviewed. The findings included: Resident #27 was admitted to the facility on February 12, 2010, with diagnoses including	F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Geri Sleeves were applied to resident # 27 bilateral upper extremities on 8-26-14. An investigation of resident # 27 bruises was completed on 8-26-14 CNA was counseled for not having geri sleeves as ordered on resident # 27 by DON on 9-15-14. All in-house residents with an order for geri sleeves were reviewed for compliance by DON on 9-9-14. Licensed staff will be in-serviced by Staff Development Coordinator on maintaining geri sleeves as ordered for assigned residents.	9-27-14

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F 309	Continued From page 7 Alzheimer's Disease, Altered Mental Status, Personal History of Urinary Tract Infection, Paranoid State, Senile Delusions, Osteoarthritis, and Difficulty in Walking. Medical record review of the Annual Minimum Data Set (MDS) dated July 8, 2014, revealed cognitive skills for daily decision making were moderately impaired, with cues/supervision required. Continued review of the MDS revealed the resident required extensive assistance of one person for bed mobility, transfer, locomotion off unit, dressing, eating, toilet use and personal hygiene. Medical record review of the Physician's Orders for August 2014, revealed an order for Aspirin (anti-inflammatory with side effects of bruising/bleeding) 81 mg (milligrams) every day. Continued review revealed, "...Geri-Sleeves (cloth-like protective sleeves designed to reduce or eliminate skin tears or sheers to the skin) to Bilateral Upper Extremities at all times except for bathing..." Medical record review of the Care Plan revealed "...Problem Onset 02/6/2010...potential risk for skin tears..." Approaches included "...Geri-sleeves to bilateral upper extremities on at all times except for bathing..." Continued review revealed "...Problem Onset 7/01/14...risk for abnormal bleeding related to aspirin use..." Approaches included, "...check skin daily for bruising..." Observation on August 25, 2014, at 11:07 a.m., in the resident's room, revealed resident #27 was seated in the wheelchair and did not have bilateral upper extremity Geri-Sleeves in place.	F 309	Risk Manager or Unit Manager will audit geri sleeve compliance 3x weeks x4 weeks 2xweeks x4 weeks 1Xweek x 4 weeks then re-evaluate continued need to audit based on findings. Results of Audits will be reviewed at Quality Assurance Process Improvement Committee meeting monthly for 3 months then re-evaluate need to continue monitoring thereafter. Quality Assurance Process Improvement Committee meeting is comprised of the: Administrator, Director of Nursing, Medical Director, Social Services Director, Risk/ Restorative Nurse, Unit Managers, Dietary Manager, Staff Development Coordinator, Wound Nurse, Health Information Manager.	

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F 309	Continued From page 8 Observation on August 25, 2014, at 2:42 p.m., revealed resident #27 lying on the bed and the resident did not have bilateral upper extremity Geri-Sleeves in place. Observation on August 26, 2014, at 7:00 a.m., in the dining room, revealed resident #27 had a dark blue, dime-size area, on the left upper extremity, approximately two inches above the bend of the elbow. Continued observation revealed the resident had another dime-size area on the upper left extremity, approximately two and a half inches above the bend of the elbow, greenish-yellow in color. Continued observation revealed resident #27 had multiple light, faded, bruise-like areas, in various stages of healing, on the bilateral forearms. Interview on August 26, 2014, at 7:14 a.m., with the South/Unit Manager, in the dining room, confirmed, "...resident is supposed to have the Geri-Sleeves on...It is a doctor's order..."	F 309		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY DT # 1 was in-serviced regarding wearing disposable gloves and safe food handling by Dietary Manager on 8-25-14. CNA #3 was in-serviced regarding wearing disposable gloves and safe food handling by Staff Development Coordinator on 8-25-14. A lunch meal dinning room audit was conducted on 9-16-14	

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F 371	Continued From page 9 by: Based on observation, facility policy review, and interview, the facility failed to maintain sanitary meal preparation practices for two residents (#110, #61) of twenty-five residents observed during the dining service. The findings included: Observation on August 25, 2014, at 12:11 p.m., of the lunch meal in the dining room, revealed resident #110 was seated at a table in the main dining room in a wheelchair. Continued observation revealed Certified Nurse Aide (CNA) #3 approached the resident at the table, placed the resident's tray in front of the resident, removed the lid from the resident's tray, and placed the lid on the table. Further observation revealed CNA #3 removed a slice of white bread from the plastic wrapper with ungloved hands, and placed the slice of bread on the resident's tray. Observaton on August 25, 2014, at 1:00 p.m., of the lunch meal in the main dining room, revealed resident #61 seated in a wheelchair at the table. Continued observation revealed Dietary Technician (DT) #1 approached the resident seated at the table, picked up the grilled cheese sandwich from the resident's tray with ungloved hands, cut the sandwich in half, and placed the sandwich back on the resident's plate. Review of facility policy, Employee Sanitary Practices, dated August 1, 2012, revealed, "...Use utensils to handle food or wear disposable gloves when necessary to handle food with their hands..."	F 371	Licensed and Dietary staff will be in-serviced by Staff Development Coordinator regarding safe food handling and use of gloves. Food handling audit during random meal times will be completed 3x week x4 weeks 2x week x4 weeks 1x week x 4 weeks then re-evaluate continued need to audit based on findings. Results of Audits will be reviewed at Quality Assurance Process Improvement Committee meeting monthly for 3 months then re-evaluate need to continue monitoring thereafter. Quality Assurance Process Improvement Committee meeting is comprised of the: Administrator, Director of Nursing, Medical Director, Social Services Director, Risk/ Restorative Nurse, Unit Managers, Dietary Manager, Staff Development Coordinator, Wound Nurse, Health Information Manager.	9-27-14

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F 371	Continued From page 10. Interview with CNA #3 on August 25, 2014, at 12:12 p.m., in the dining room, confirmed gloves had not been worn while handling the resident's food. Interview with DT #1 on August 25, 2014, at 1:10 p.m., confirmed gloves had not been worn while handling the resident's food. Interview with the Director of Nursing (DON) on August 26, 2014, at 6:58 a.m., in the DON's office, confirmed the CNA failed to follow the facility's policy for handling the resident's food.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS CNA # 2 was in-serviced related to washing her hands or using hand sanitizer to avoid cross contamination between residents by DON on 9-15-14 A lunch time meal delivery audit was completed on 300 hall on 9-16-14. Licensed staff will be in-serviced by the Staff Development Coordinator regarding infection control principles of prevent cross contamination during delivery of meal trays with emphasis on hand washing and / or use of hand sanitizer.	9-27-14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445160	A. BUILDING _____ B. WING _____	08/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 11 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to follow current infection control principles to prevent cross contamination during the delivery of mealtrays for one hallway (300 hall) of four hallways observed. The findings included: Observation on August 25, 2014, at 11:23 a.m., during mealtray delivery on the 300 hallway, revealed the Certified Nurse Aide (CNA) #2 used the left hand to push hair back, over the left ear, and coughed into the left hand. Continued observation revealed CNA #2 obtained a mealtray from the cart and walked into a resident's room, without washing or sanitizing the hands. Observation on August 26, 2014, at 7:29 a.m., during mealtray delivery on the 300 hallway, revealed CNA #2 opened the meal cart door, took the left hand and pushed the hair back behind the left ear. Continued observation revealed CNA #2	F 441	Random meal time delivery audits will be completed 3x week x4 weeks 2x week x4 weeks 1x week x 4 weeks then re-evaluate continued need to audit based on findings. Results of Audits will be reviewed at Quality Assurance Process Improvement Committee meeting monthly for 3 months then re-evaluate need to continue monitoring thereafter. Quality Assurance Process Improvement Committee meeting is comprised of the: Administrator, Director of Nursing, Medical Director, Social Services Director, Risk/ Restorative Nurse, Unit Managers, Dietary Manager, Staff Development Coordinator, Wound Nurse, Health Information Manager.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 12 obtained a mealtray from the tray cart and delivered the tray to a resident without washing or sanitizing the hands. Review of the facility policy, Employee Sanitary Practices, effective date August 1, 2012, revealed,"...do not touch hands to mouth or face while...serving food...will not cough or sneeze near food or dishware...wash hands after these occurrences... " Interview with the Director of Nursing (DON) on August 26, 2014 at 8:00 a.m., in the DON's office, confirmed, "The CNA should have washed the hands before handling another mealtray... "	F 441		